Ryan White

1971—1990

NEMA NEWS

Congratulations Dean Johnson!

FEATURED IN THIS ISSUE

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UMDNJ Appoints Robert Johnson as Permanent Dean of Newark Medical School

(Reprinted from article)

By Kelly Heyboer/ The Star-Ledger

After nearly six years and two national searches, New Jersey Medical School has a new dean — and he's a familiar face.

Robert Johnson, who has served as interim dean since 2005, was named the permanent dean of the University of Medicine and Dentistry of New Jersey's Newark medical school, campus officials announced today.

"It's been a while," said Johnson, 64. "This school and university have been through a lot."

Johnson replaced former dean, Russell Joffe, nearly six years ago, expecting to fill the post for a few months while a national search identified a new dean for the 750-student medical school.

UMDNJ launched the search, but naming a new dean was put on the back burner while the university dealt with years of upheaval during a federal investigation into waste, fraud and mismanagement. The investigation led to a two-year federal takeover of the university and the appointment of a new president.

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Note: The general public is encouraged to attend the Council meetings and provide written and/or oral testimony on issues pertaining to the care & treatment needs of People Living With and Affected by HIV/AIDS who reside in the Newark EMA: namely Essex, Morris, Sussex, Union and Warren Counties. Minutes of Council and Committee meetings are available by request at the Planning Council office or on our Web page.

Nota: Se anima al pública en general en atender a las reuniones del concilio y proveer testimonio oral y/o escrito sobre situaciones pertenecientes a las necesidades de cuidado y tratamiento de las personas que viven con y son afectadas por el VIH/SIDA y que viven en Newark EMA; es decir Essex, Morris, Sussex, Union, y Warren. Resumen de los reuniones de Concilio y de los comités están disponibles a petición en la oficina de Concilio.

Visit us on the Web at:

www.NewarkEMA.org

The comments expressed in this newsletter are not necessarily those shared by the Newark EMA HIV Health Services Planning Council. Any comments regarding the newsletter should be sent in written correspondence to the Editorial Board at the above address.

Los comentarios expresados en este periódico no son necesariamente los compartidos por el Concilio de Planificación de Servicios a la Salud de Newark EMA. Cualquier comentario en relación al periódico debe ser enviado por escrito a la Junta Editorial a la dirección mencionada.

Helpful Websites for the Consumer

- AIDS Information: www.aidsinfo.nih.gov
- NJ Housing Resource Center: www.njhousing.gov/njhrc/consumers/specneeds/hiv-aids.html
- Everything HIV and AIDS in NJ: http://hiv-aids-nj.com

www.TheBody.com— Offers information on HIV Prevention and treatment, major conferences, online community discussion, and the "ask-the-experts" feature. Also maintains a companion site for providers: www.TheBodyPro.com

- AIDSinfo – A merger of HIV/AIDS treatment service and AIDS clinical trials information service; offers information on clinical trials and treatment issues.
- NJ HIV Planning Group: www.HPCPSDI.Rutgers.edu/NJHPG

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2011 Planning Council Meetings

November 16th 1:30pm @ NEMA Office
December 21st 1:30pm @ NEMA Office

2011 Committee Meetings

(Held at the Planning Council Office)

Continuum Of Care @ 9:30AM on Thursday:
Nov 10, Dec 8

Community Service Advisory @ 2:00PM on Thursday:
Nov 10, Dec 8

Comprehensive Planning @ 9:30AM on Friday:
Nov 4, Dec 9

Research & Evaluation @ 10:00AM on Monday:
Nov 21, Dec 19

2011 Upcoming Events

November- National AIDS Awareness Month

December 1- World AIDS Day

UMDNJ's board launched a second national search for a new dean last year, including Johnson among the candidates. The board voted Tuesday to appoint Johnson permanent dean.
Johnson has a long history at UMDNJ, where he was the only African-American in New Jersey Medical School's 1972 graduating class. He eventually became the school's chairman of pediatrics.

"When I attended New Jersey Medical School I learned pediatrics from Dr. Johnson, so I can personally attest to his talents as an educator, mentor, and most important to his skills as a kind and compassionate physician," said Kevin Barry, chairman of UMDNJ's board and an anesthesiologist.

Johnson, of Orange, will be paid $500,000 a year as dean, the same salary he earned in the interim job, campus officials said.

The dean said he has a long to-do list that includes preparing for the medical school's accreditation in 2013 and guiding the school through a possible reorganization of UMDNJ. He also plans to take a close look at all of New Jersey Medical School's departments.

“I want to do a thorough study of the school, mission by mission," Johnson said.

Earlier this year, a task force convened by Gov. Chris Christie recommended restructuring UMDNJ and giving Robert Wood Johnson Medical School, one of the university’s other schools, to Rutgers University.

The PDSA Cycle is a QM tool for developing a corrective action plan. P is for planning. Once the area of deficiency has been identified, a remediation plan should be developed. The plan should identify the target population; for example if cervical cancer screenings were selected, the target population would be HIV+ women who have not had a hysterectomy. The plan should include the start and end date which should be a short amount of time. An effective PDSA cycle can be conducted in one day, dependent upon the total patient population and the indicator selected. The plan also needs an administrator, a data collector, and data analyzer. The D stands for Do. Once the plan has been developed, the process should begin on the designated start date. The S is for study. The data should be analyzed and compared to the initial chart review data. The A is for act. If the adherence rate for the PDSA cycle exceeds the chart review analysis, this plan can be adopted for policy. Should the PDSA cycle results show no improvement, the team should discuss the results, determine the pitfalls and develop a new PDSA cycle.

Quality management committee reports should be shared with the entire clinical staff. Quality improvement requires a team approach and each member of the team plays an important role in the QM process. Ensuring that patients remain in care and sustain an undetectable viral load is not just the responsibility of the health care provider. That responsibility begins with the clerk who schedules the appointment, and includes the nurse who takes the vital signs, and the case manager who assists the patient with his/her psychosocial needs. Most importantly, the patient needs to be educated about the importance of keeping appointments and taking medications as prescribed - a message which may need repeating over and over again until it sinks in. The end result is the patient who has been HIV positive for twenty-five years with a Cd-4 count of 750 and an undetectable viral load.

Dr. Johnson and television host Steve Adubato on “Caucus Up Close”

Forty Years of Failure

Excerpted from the website of Drug Policy Alliance

This year marks the 40th anniversary of the war on drugs – a critical time to shine a spotlight on 40 years of failed policy.

Since the declaration of a "war on drugs" 40 years ago:

- America has spent at least $1 trillion on the drug war. It cost U.S. taxpayers at least $51 billion in 2009 at the state and federal level. That's $169 for every man, woman and child in America – and that's not counting opportunity costs or costs at the local level.

- Millions of people have been incarcerated for low-level drug law violations, resulting in drastic racial disparities in the prison system, yet drug overdose, addiction and misuse are more prevalent than ever.

Hundreds of thousands of lives have been lost to overdose and drug-relate disease because cost-effective and lifesaving interventions are not sufficiently available.

Group 3

INDICATOR	HOW MEASURED
Chlamydia Screening	% of HIV+ clients at risk for STIs who had test for Chlamydia in the measurement year
Gonorrhea Screening	% of HIV+ clients at risk for STIs who had test for Gonorrhea in the measurement year
Hepatitis B Screening	% of HIV+ clients screened for Hepatitis B virus infection
Hepatitis/HIV Alcohol Counseling	% of HIV+ clients with Hepatitis B and/or C infection who received alcohol counseling in the measurement year
Influenza Vaccination	% of HIV+ clients who received influenza vaccination in the measurement year
MAC Prophylaxis	% of HIV infected clients with CD4 count below 50 cells prescribed Mycobacterium avium complex prophylaxis in the measurement year
Mental Health Screening	% of HIV+ clients who had a mental health screening
Pneumococcal Vaccination	% of HIV+ clients who have ever received pneumococcal vaccine
Substance Use Screening	% of HIV+ clients screened for substance use in the measurement year
Tobacco Cessation Counseling	% of HIV+ clients who received tobacco cessation counseling in the measurement year
Toxoplasma Screening	% of HIV+ clients who received toxoplasma screening at least once since HIV diagnosis

Monitoring the HRSA/HAB indicators is accomplished through chart audits. Each clinical site should maintain a quality management committee charged with reviewing patient charts periodically for predetermined indicators. The committee should review the results, and develop a PDSA cycle for improvement.

Group 1

INDICATOR	HOW MEASURED
Antiretroviral Therapy for Pregnant Women	% of HIV+ pregnant women prescribed ART
CD4-T-Cell Count	% of HIV+ clients who had two or more Cd4 T-cell counts performed in the measurement year at least 3 months apart
Antiretroviral Therapy	% of clients with AIDS prescribed ART
Medical Visits	% of HIV+ clients who had 2 or more medical visits in the measurement year at least 3 months apart
Pneumocysttis jiroveci Pneumonia (PCP) Prophylaxis	% of HIV infected patients with a CD4 count less than 200 cells prescribed PCP prophylaxis

Group 2

INDICATOR	HOW MEASURED
Adherence Assessment and Counseling	% of HIV+ clients on ART assessed and counseled for adherence two or more times in the measurement year
Cervical Cancer Screening	% of HIV+ women who received a PAPanincolaou screening in the measurement year
Hepatitis B Vaccination	% of HIV+ clients who completed the Hepatitis B vaccination series
Hepatitis C Screening	% of HIV+ clients with a Hepatitis C screening at least once since HIV diagnosis
HIV Risk Counseling	% of HIV+ clients who received HIV risk counseling within the measurement year
Lipid Screening	% of HIV+ clients on ART who had a fasting lipid panel in the measurement year
Oral Examination	% of HIV+ clients who received an oral examination by a dentist at least once during the measurement year
Syphilis Screening	% of HIV+ clients tested for syphilis in the measurement year
Tuberculosis Screening	% of HIV+ clients who received testing with results documented for latent tuberculosis infection

The war on drugs drives mass incarceration of Americans:

- More than 1 of every 100 American adults is behind bars. In 1980, the total U.S. prison and jail population was about 500,000 – today, it is more than 2.3 million.
- The U.S. incarcerates more people than any country in the world – both per capita and in terms of total people behind bars. The U.S. has less than 5 percent of the world's population, yet it has almost 25 percent of the world's incarcerated population.
- The number of people behind bars for drug law violations rose from 50,000 in 1980 to more than a half of a million today – an 1100% increase.

Syringe Access Advocates Work on *Campaign for a Healthier New Jersey* to Fight for Over-the-Counter Sale of Syringes

Roseanne Scotti, New Jersey State Director,
Drug Policy Alliance

HIV/AIDS prevention advocates are redoubling their efforts for the *Campaign for a Healthier New Jersey*. The campaign was launched in 2002 to advocate for increased access to sterile syringes in order to prevent the spread of HIV/AIDS, hepatitis C and other blood-borne diseases and to make syringe access easier for diabetics and others who must use injectable medications.

The work of this campaign has been particularly important because New Jersey has been so far out of the mainstream in terms of state syringe access policies. New Jersey is one of only two states that completely ban over-the-counter sale of syringes. New Jersey's HIV/AIDS rates have been among the highest in the nation since the emergence of the HIV/AIDS epidemic, yet until 2006, New Jersey refused to allow for syringe exchange programs which have been proven to reduce HIV/AIDS risks.

In 2006, the campaign won a major victory when the *Blood-Borne Disease Harm Reduction Act* passed. The *Act* permitted the establishment of syringe access programs in six cities. Unfortunately, another bill to allow for over-the-counter sale of syringes failed to get enough votes to get out of committee. Now, the members of the *Campaign for a Healthier New Jersey* are making a renewed advocacy effort to get this legislation passed. The bill, Senate Bill 958, would allow the sale of up to ten syringes, to an adult, in pharmacies without a prescription.

QUALITY IMPROVEMENT MEANS BETTER PATIENT OUTCOMES

By Brenda Christian

In 2006 the Ryan White Treatment Modernization Act directed grantees to establish a clinical quality management program. Since that time quality improvement (QI) has become standard practice for HIV programs across the United States.

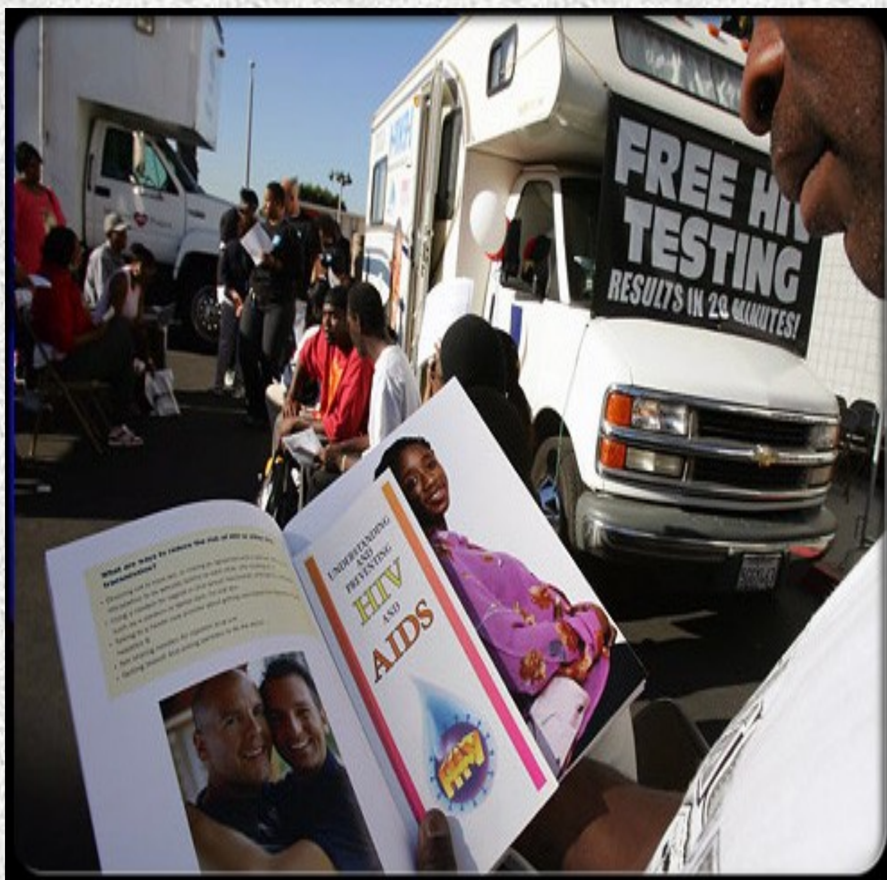
For clinicians busy providing care for their patients, QI may seem like a labor intensive daunting experience. But understanding the benefits of the program, along with acquiring the tools needed to facilitate the process makes QI both rewarding and time efficient.

Quality improvement is directly associated with patient outcomes. The ultimate goal in patient management is to keep the patient in care and maintain viral suppression. To achieve this goal, the Department of Health and Human Services (DHHS) has developed Guidelines for the treatment of HIV-Infected Adolescents and Adults, and the Health Resources and Services Administration (HRSA), in conjunction with the HIV/AIDS Bureau (HAB) have developed three groups of Clinical Performance Measures to help monitor the effectiveness of current practices.

For more information and appointments, contact:

Smith Center for Infectious Diseases and Urban Health
310 Central Avenue, Suite 307, East Orange, NJ
Or
800 Broad Street, Newark, NJ
(862) 772-7822

*This project is funded by a grant from the Healthcare Foundation of New Jersey



Senate Bill 958 is a reasonable and common sense approach to allowing access to syringes to those who need them for health reasons.

Senate Bill 958 is supported by a broad array of public health and social service organizations in New Jersey including the American Diabetes Association, the Garden State Diabetes Educators, the New Jersey State Nurses Association, the New Jersey Academy of Family Physicians, the Garden State Pharmacy Owners, the New Jersey Pharmacists Association, the Independent Pharmacy Alliance, New Jersey Council of Chain Drug Stores, the New Jersey Hospice and Palliative Care Organization, Homeside Hospice, Hepatitis C Association, Hyacinth AIDS Foundation, the New Jersey Hospital Association, South Jersey AIDS Alliance, Camden AHEC, the American Civil Liberties Union of New Jersey and Well-of-Hope Drop-In Center.

TABLE 2. Number and percentage of syringe exchange programs (SEPs),* by selected supplies and services provided — United States, 2005

Supplies and services	No.	(%)
Prevention supplies		
Male condoms	115	(97)
Female condoms	98	(83)
Alcohol pads	117	(99)
Bleach	82	(69)
On-site medical screenings and services		
HIV counseling and testing	96	(81)
Hepatitis C counseling and testing	66	(56)
Hepatitis B counseling and testing	44	(37)
Hepatitis A counseling and testing	28	(24)
Hepatitis B vaccination	46	(39)
Hepatitis A vaccination	43	(37)
Sexually transmitted disease (STD) screening	57	(49)
Tuberculosis screening	33	(28)
On-site medical care	34	(29)
Referrals		
Substance-abuse treatment	102	(86)
Education		
HIV/AIDS prevention	116	(98)
Hepatitis A, B, and C prevention	114	(97)
Safer injection practice	113	(96)
Vein care	110	(93)
STD prevention	110	(93)
Abscess prevention	107	(91)
Male condom use	112	(95)
Female condom use	97	(82)

* N = 118.

Generation HIV: Young Gay Men At Risk

There's one group that is seeing HIV rates accelerating: twenty-something gay men

By Joe Erbentraut *Wednesday, Jun 22 2011*

Three decades ago, the sexual revolution skidded to a halt when the Centers for Disease Control and Prevention first reported a bizarre strain of pneumonia besieging gay men. After having decimated an entire generation, AIDS now threatens another. Today, young gay and bisexual men (especially men of color) are responsible for the most alarming surges in new HIV diagnoses and represent the only demographic group whose rates of infection have continued to climb each year since antiretroviral drug therapies introduced in the mid-'90s gave patients hope.

The highest rate of new HIV infections are occurring among black men 13 to 29 who have sex with men.

Welcome to Generation H, the twentysomething queers who've never known a world without AIDS and yet appear reluctant to use condoms.

Advocates and health workers are scratching their heads and asking, "Who or what is to blame for so many young gay men contracting HIV? Rebellion? Complacency? Arrogance? A desire to self-annihilate?"

Get Out the Tests

By Steven Smith, M.D.

Most Ryan White HIV care and service providers are familiar with the CDC's estimate that 1 in 5 people living with HIV are unaware of their status. Get Out The Tests, or **GOTT**, is Smith Center's answer. Through outside funding, the Smith Center for Infectious Diseases and Urban Health is set to start our innovative infectious disease testing initiative.

GOTT builds on our success with financial incentives to hopefully reach out to those 1 in 5. We will make use of current Smith Center patients, called *Patient Recruiters,* to make their own outreach to community members. By paying *Patient Recruiters* $10 per person, we hope that they can help us find people who have never or rarely been tested for HIV.

Once a person presents for **GOTT**, they will get $10 for receiving a panel of infectious disease tests. This will include syphilis, gonorrhea, chlamydia, herpes, tuberculosis, hepatitis A, B, and C, and of course, HIV. Upon returning for their results, they will receive another $25. If they test positive for any of the tests, we will offer treatment on-site.

We believe that **GOTT** will have several positive effects. First of all, increased testing and treatment for HIV and other infectious diseases will help curb the spread of disease. Second, by incentivizing the testing process *and* utilizing community member peers to recruit, we will have a further reach into the community. This will increase the breadth of testing and allow us to assess their reason for not testing before. Surveillance of this kind is lacking from current epidemiologic data and can potentially inform future testing strategies.

Maybe it's because they've missed the most effective prevention program of all: funerals. "They don't realize what we went through, but that's human nature," says Mark King, who blogs MyFabulousDisease.net. "If I wasn't there, I don't get it and I don't have time to listen to you because I'm 26 and my friends are waiting for me at the club. And that's exactly how we behaved. The only thing that made it different for us is that we were living in a horror movie."

Sean Strub, a veteran AIDS activist and founder of *POZ* magazine, doesn't buy the argument that young gay men "don't get it" when it comes to HIV. On the contrary, he argues that Generation H is "healthier about their sexuality—especially in self-acceptance—than any previous generation of gay men in recent history. They also are quite sophisticated. Part of the reason they turn off and don't heed safer-sex messages is because they've figured out that many of those messages are overly cautious, not heeded by nearly everyone, and paint a picture of an unlikely outcome."

For Michael Tikili, 25, the "unlikely" outcome of an HIV diagnosis became a reality for him almost two years ago. But he sees seroconverting (becoming HIV-positive) as actually having changed his life—and not all bad.

"Everyone that doesn't have it thinks it is the worst thing in the world, but we need to stop looking at it as a death sentence because it's not," he says. "You can lead a healthy life with HIV."

The experience of the virus for Tikili and his friends include seeing healthy, humpy guys living with HIV, as well as six-packed models in omnipresent pharmaceutical ads touting the medications that have allowed those infected with the virus to live near-normal lives. You have to read the fine print to understand the nasty side effects of, and eventual resistance to, these wonder drugs. Nor do the ads mention how expensive they are.

James Krellenstein, 20, works at Yale University School of Medicine and founded a website about post-exposure prophylaxis, the "morning-after pill" (actually, a month-long regimen of pills) for people who believe they may have been exposed to HIV. Owing to the success of new therapies, he believes that the problem lies in safer-sex messages "framed in a shame-oriented way coming from the basic premise that you shouldn't be having sex, and if you do so, be sure to use a condom every time for everything. It's as if there's something bad or irresponsible about it. People start to shut down when they hear that sort of judgment." Critics cite the New York Health Department's controversial "It's Never Just HIV" campaign, which shows images like a cancer-inflamed anus. They believe the ads only make people more anxious about getting tested—at a time when nearly two-thirds of queer men 18 to 29 are oblivious of their status (according to a 2010 CDC report).

The natural response for many has been the eroticization of risk-taking. The trend, called barebacking, has become so popular in gay porn that condom-free load-shooting orgies are top sellers.

"Human rights violations, legal barriers and discrimination have played a central role in blocking MSM from accessing life-saving services," said Krista Lauer, Policy Associate at the MSMGF. "With fewer than one in ten MSM around the world able to access even the most basic prevention and treatment, this declaration has the potential to make a major difference for MSM. After 30 years of trying to control the epidemic with generalized responses, the document signals a shift toward policies and programs that respond to communities at highest risk, an approach shown to be both more effective and more cost-efficient."

By adopting these and other strategies, the declaration makes a number of time-bound commitments, including reaching 15 million people with anti-retroviral drugs by 2015.

The negotiations leading up to the adoption of the declaration considered questions of culture, sovereignty, and religious values, and a number of provisions included in the final text could potentially undermine or dilute a targeted focus on MSM and other key populations. In addition, while the declaration acknowledges MSM, sex workers, and people who inject drugs by name, transgender people were omitted from the document despite infection rates of over 30% "There is obviously a long way to go," said Dr. Ayala. "The document is not perfect, but it makes strong commitments to very important goals and sets forth a number of solid principles to achieve them. It is now up to civil society to work together to hold governments accountable. The prevention and treatment goals enshrined in this document cannot be met unless the global AIDS response is re-shaped to address MSM and other key populations."

The Global Forum on MSM & HIV (MSMGF) is an expanding network of AIDS organizations, MSM networks, and advocates committed to ensuring robust coverage of and equitable access to effective HIV prevention, care, treatment, and support services tailored to the needs of gay men and other MSM. Guided by a Steering Committee of 20 members from 18 countries situated mainly in the Global South, and with administrative and fiscal support from AIDS Project Los Angeles (APLA), the MSMGF works to promote MSM health and human rights worldwide through advocacy, information exchange, knowledge production, networking, and capacity building

For First Time, UN Political Declaration on AIDS Addresses HIV among Men Who Have Sex with Men

Creates Unprecedented Opportunities and Highlights Challenges in Struggle for Health and Human Rights

June 10, 2011 (New York) – The Global Forum on MSM & HIV (MSMGF) welcomes the progress represented in the new 2011 United Nations Political Declaration on HIV and AIDS, expected to be formally adopted later today at the conclusion of this week's High Level Meeting on AIDS in New York. Issued as a consensus statement with support anticipated from all UN member states, the declaration is the first General Assembly statement on AIDS to explicitly include men who have sex with men (MSM), breaking a pervasive silence about this population at the official level and creating unprecedented opportunities for advocacy to promote MSM health and human rights.

"The inclusion of men who have sex with men and other key populations is a major turning point in the global political discourse that has dominated the first 30 years of global HIV response," said Dr. George Ayala, Executive Officer of the MSMGF. "Political leadership is finally catching up with public health evidence. With HIV rates among MSM now surpassing thirty percent in countries from Asia to the Caribbean, this language is well overdue."

The declaration sets forth a series of principles and recommendations for an enhanced response to HIV. Calling for a tailored, evidence-based approach, the document recognizes that the full realization of human rights for all people is an essential part of the global AIDS response. The declaration also commits to the creation of enabling legal, social and policy frameworks to promote access to essential services, as well as the review of laws and policies that adversely impact the equitable delivery of HIV prevention, treatment, care and support.

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But don't swallow the media hype that young gay men are bug chasers seeking out partners with whom they might contract the virus. New research indicates that most infections among gay men take place within a relationship. A 2009 study reported that well over three-quarters of under-30-year-olds received the virus from their main sex partners. A hesitancy around or resistance to condom use, then, appears to have more to do with a desire for closer intimacy.

"It is a natural thing to want to have skin-on-skin contact and to share fluids," says Jim Pickett who works for the AIDS Foundation of Chicago and blogs under LifeLube.org. "We allow this for heterosexuals and throw baby showers for the results of heterosexual 'barebacking.' But the idea that all men, all humans, can use condoms consistently and correctly every time they have sex for their entire sexual lives is crazy. It is one option, but you need to provide options to people. We need to reframe all of this so that it makes sense for the lives people are living."

The one thing all advocates agree on is throwing out federally mandated abstinence-only sex education in public school. As for queer-specific information, forget it. Sean Cahill, who directs public policy and community health at Gay Men's Health Crisis, believes that "we're now entering a period where science has replaced ideology among federal policy makers. There is a lot more support and willingness for science-based HIV and more broad sexual-health education."

SILENCE=DEATH